MIAMIBEACH
HUMAN RESOURCES DEPARTMENT

FAMILY AND MEDICAL LEAVE (FML) REQUEST / AUTHORIZATION FORM

Human Resources must receive the signed, completed original of this form in order to process FML. Human Resources should receive this form at least 30 days prior to first date of absence for any type of foreseeable FML.

NAME: _____ **ID#:** _____

DEPT./DIVISION: _____ **Phone #:** _____

A. I am requesting family/medical leave:
   ( ) 1. due to the birth of a child, or placement of a child for adoption or foster care.
   ( ) 2. due to a serious health condition that makes me unable to perform the essential functions of my job.
   ( ) 3. due to a serious health condition affecting my ( ) spouse, ( ) child under 18 years of age, ( ) child over 18 years of age who is incapable of self-care due to a physical or mental disability, ( ) parent, for whom I am needed to provide care.
   ( ) 4. to care for my ( ) spouse, ( ) child, ( ) parent, ( ) next of kin, who is a member of the Armed Forces (including a member of the National Guard or Reserves), who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of his/her office, grade, rank, or rating (otherwise known as Servicemember Family Leave). Define the relationship for "next of kin" (i.e. sibling, aunt, uncle, grandparent, etc.): _____
   ( ) 5. due to a qualifying necessity arising out of the fact that my ( ) spouse, ( ) child, ( ) parent, is on active duty (or has been notified of an impending call to order to active duty) in the Armed Forces in support of a contingency operation (otherwise known as Qualifying Exigency Leave).

B. I will need this leave beginning _____ (date) and I expect the leave to continue until _____ (date). If leave is intermittent, describe expected intervals and duration of intervals of leave: _____

C. I have ____ have not ____ worked for the City of Miami Beach for at least 12 months. I have worked at least 1250 hours in the past 12 months. I have used less than 480 hours of FML in the past 12 months (1040 in the case of Servicemember Family Leave).

D. I request to use the following number of hours: ____ floating holidays/birthday, ____ sick, ____ annual, and/or ____ personal leave without pay due to the above indicated reason, which will prevent me from reporting to my job on the days indicated. **I understand that FML will be used concurrently with any other applicable leave programs, and not consecutively.**

E. I understand that if I am taking intermittent FML, I must make appointments at dates and times least disruptive to my department (including before and after work, and/or on my days off). It is my responsibility to make appointments as far in advance as possible and to give the department as much advance notice as possible.

F. ( ) If any of my leave is without pay, I would like for my department to request leave donations from the following individuals. **I understand that this only applies if the leave is for my own personal injury or illness.** (HR will notify department of when leave is without pay so that request can be sent.)
   ( ) all city employees
   ( ) employees in my department only
   ( ) only the following employees (list specific names): _____
   ( ) If any of my leave is without pay, I do not want to request leave donations.

G. If any of my leave is leave without pay, I understand that I must contact the Benefits Division of Human Resources to arrange for the continuation of my health insurance benefits.

H. If I have used or if I am requesting to use more than the maximum of 12 weeks (or 480 hours intermittently), prior to the end of the initial 12 week period (or 480 hours), I may request up to 12 additional weeks FML for all FML leave except for Service Member Family Leave. I understand that approval is subject to the current operational needs of the department considering my job duties and area of assignment. The request is reviewed by the Appointing Authority and is subject to the approval the Human Resources Director (or designee).

I. **I understand that I must return to work when approved FML has expired.**

J. For all FML leave requests except for Call to Active Duty Leave, please provide:

Name of patient's health care provider: _____

Number of times patient has been seen by health care provider: _____

K. I certify that all of the information on this application and on any documents I have submitted is true, accurate and complete to the best of my knowledge. I understand that all information and documents are subject to investigation and that exaggeration, falsification, misrepresentation, or omission is sufficient cause for disqualification, immediate dismissal from the City Service and/or disqualification from applying for any position in the service of the City of Miami Beach.

**** EMPLOYEE SIGNATURE:** _____ **DATE:** _____

AUTHORIZATION TO CLARIFY AND AUTHENTICATE MEDICAL CERTIFICATION

Pursuant to 29 CFR 825.307, if an employer questions the adequacy of a medical certification, the employer may not request additional information from the employee's health care provider. However, a health care provider representing the employer may contact the employee's health care provider, with the employee's permission, for purposes of clarification and authenticity of the medical certification.

I authorize my employer's health care provider to contact my health care provider to clarify and authenticate the FML medical certification provided by me to my employer. I understand that my authorization is voluntary and that I can refuse to sign this authorization.

**** EMPLOYEE SIGNATURE:** _____ **DATE:** _____

DEPARTMENT DIRECTOR TO COMPLETE BELOW IF THIS IS A REQUEST FOR FML EXTENSION OR TO USE MORE THAN THE MAXIMUM OF 12 WEEKS (OR 480 HOURS INTERMITTENT) FML.

The Department's approval of additional FML is subject to the current operational needs of the department considering the employee's job duties and area of assignment. The request is also subject to the approval the Human Resources Department.

Indicate whether the request is approved, and if not, why not: _____

_____

**** DEPARTMENT DIRECTOR SIGNATURE:** _____ **DATE:** _____

FML APPROVAL/DENIAL NOTIFICATION TO EMPLOYEE AND DEPARTMENT

(Human Resources to Complete)

TO: _____ _____ Human Resources Compensation
(Employee's Name)

VIA: _____ _____ Human Resources Insurance
(Employee's Department Director)

FROM: _____ DATE: _____
(HR Representative)

This is to inform you that you are ( ) eligible ( ) not eligible for leave under the FMLA. If not eligible, reason(s) denied: _____.

( ) 1. You are required to furnish medical certification of serious health condition by _____ (date) or we may delay commencement of FML until form is submitted.

( ) 2. You are required to furnish the following documentation by _____ (date) or we may delay commencement of FML until documentation is submitted.
Documentation Required: _____

( ) 3. You are required to present fitness for duty certificate prior to being restored to employment. If such certification is not received, your return to work may be delayed until it is provided.

( ) 4. You will be required to furnish the City with periodic reports from the attending physician every _____ (interval of periodic reports) of your status and intent to return to work (See 825.309 of FMLA Regulations.) Failure to provide requested reports will result in discontinuance of FML.

( ) 5. Employee is approved for a maximum combined total of 480 hours of FML for all FML purposes combined in a rolling 12 month period. Employee and department will monitor number of hours to ensure it does not exceed the maximum 480.

( ) 6. Employee is approved for a maximum combined total of 960 hours of FML for all FML purposes combined in a rolling 12 month period. Employee and department will monitor number of hours to ensure it does not exceed the maximum 960.

( ) 7. Employee is approved for a maximum combined total of 1040 hours of FML for all FML purposes combined in a 12 month period. Employee and department will monitor number of hours to ensure it does not exceed the maximum 1040.

( ) 8. Employee is approved for a maximum combined total of ____ hours of FML for all FML purposes combined in a 12 month period. Employee and department will monitor number of hours to ensure it does not exceed the maximum ____.

Signed: _____
(HR Representative)

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

(When completed, this form goes to the employee,	OMB No.: 1215-0181 Expires: 08-31-2007
1. Employee's Name	2. Patient's Name *(If different from employee)*

3. Page 4 describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

(1)_____ (2) _____ (3) _____ (4)_____(5) _____ (6) _____ , or None of the above _____

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

b. Will it be necessary for the employee to take work only **intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 6 below)?

If yes, give the probable duration:

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of **episodes of incapacity**[2]:

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

6. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

c. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (*e.g.*, prescription drugs, physical therapy requiring special equipment):

7. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind?

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**?

8. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need:

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment[3] two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (3) May cause **episodic** rather than a continuing period of incapacity[2] (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity[2] of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

*U.S. GPO: 2000-461-954/25505